CHAPTER 3: PRIORITY POPULATIONS, INTERVENTIONS, AND GOALS

This Chapter summarizes the key needs assessment findings for each priority population and lists the priority interventions and prevention goals. The Chapter also summarizes the priority setting process used to determine priority populations and interventions.

Overview

The priority setting process was conducted by the CPG during 2000. As a result of the priority setting process the following populations and interventions were selected as priorities.

TARGET POPULATIONS (Ranked)	INTERVENTIONS (Unranked)
African American Men who have Sex with Men (MSM), Ages 15-44	Group Level
African American Women who have Sex with Men (WSM), Ages 15-44	Group Level Individual Level
White Men who have Sex with Men (MSM), Ages 15-44	Group Level Community Level
African American Male Injection Drug Users (IDU), Ages 20-44	Individual Level Group Level Community Level
African American Female Injection Drug Users (IDU), Ages 20-44	Individual Level Group Level Community Level Outreach
White Male Injection Drug User (IDU), Ages 20-44	Group Level Outreach

Priority Populations, Interventions, and Goals for 2002-2004

The priority target populations for 2002-2004 are presented in priority order on the following pages. For each target population there is included a summary description of the target population, a list of sub-populations of concern, barriers to reaching the population, priority interventions, and goals. Following the priority population descriptions, there is a separate section of selected subpopulations of concern that were not included in our priority list above.

Since the 2000 priority setting, the Needs Assessment workgroup reviewed the Epi Profile and determined that African American Men Who Have Sex With Women should be a priority population for further needs assessments, therefore it is included in the following populations

description. During the next prioritization process (during 2002 – 2004), priority interventions for this population will be developed.

The interventions prioritized in 2000 were specifically health education /risk reduction interventions (HE/RR). These priority interventions selected in 2000 (listed above) for each population are highlighted in the following section. Following the 2000 priority HE/RR interventions, are other listed priority interventions based on subsequent needs assessment and literature information, and recommendations by the CPG. The CPG has determined that the interventions will be prioritized in rank order after obtaining South Carolina specific input based on Phase II of the Needs Assessment focusing on the target populations.

Broad prevention goals are listed for each priority population in the following pages, as well as in Chapter 7: Goals and Objectives.

Target Population 1: African American Men Who Have Sex With Men

Estimated Size: Minimum of 14,428 men, ages 15 - 44

There are significant prevention challenges related to African American Men Who Have Sex With Men (AAMSM) in South Carolina, similar to other southeastern states. Few programs are targeted toward this population, and even fewer of the existing programs have demonstrated success in reaching them. Access to the population is difficult due to secrecy of the activity, denial of African American MSM engaging in same sex activities and the double stigmas of racism and homophobia. The majority of AAMSM often identify themselves as heterosexual. Thus, there is not a defined open "community" to focus needs assessments, target information or provide support. Further, the lack of family and religious institution support of sexuality issues reduces the population's access to preventive health services. There is a lack of information on proven effective interventions for this population, particularly in rural areas. Culturally reflective staff, including peers, are often not available to deliver the interventions.

Sub-Populations of Concern

Youth and young adults < 25 years	HIV Infected	Sex Workers
Incarcerated	Bisexual/ "married" men	
Substance Users	Transgenders	

Barriers To Reaching Population

Denial of MSM activities	Rural areas more isolated
Prejudice and stigma towards race and MSM	Cultural and language barriers
Not receptive and accessible to prevention messages/services	Complacency
Economic disenfranchisement	

Priority Interventions*

- Group Level: Peer and Non-Peer Counseling and Risk Reduction Education, Skills Training and Social Support
- Culturally appropriate community-level prevention marketing in settings targeting African American men (inclusive of MSM), e.g. church programs, youth rallies, basketball events, barber shops, concerts, etc.
- Community delivered counseling and testing

Goals

1. Decrease risk behavior and number of sexual partners.
2. Increase support among larger African American communities for HIV prevention and reduced stigma.
3. Increase integration of HIV in substance use, other broader health/support issues groups that are sensitive to MSM populations.
4. Increase number of African American MSM who have knowledge of their HIV status and are referred to on-going care and support services.
5. Develop behavioral monitoring mechanisms for improved planning/interventions.

***NOTE: Highlighted interventions indicate the 2000 priority interventions for each population.**

Target Population 2: African American Women Having Sex With Men

Estimated Size: 305,179 women, ages 15 - 44

African American women comprise nearly one quarter of the persons living with HIV (24%) in South Carolina, the second highest proportion following African American men. Among recently reported cases during 2000, African American women accounted for 29% of the total reported cases, compared to 15% among white men and 5% white women. This trend is similar across southern states where joblessness, substance abuse, teenage pregnancy, STD's inadequate schools, minimal access to health care and low incomes contribute to the increasing rates of HIV among this population. In addition, African American women are frequently unknowingly placed at risk by their male sexual partners who are more likely to be HIV infected through male to male sex and substance use. Women are often in power imbalanced relationships and perceive themselves as "victims" which creates significant challenges for prevention.

Sub-Populations of Concern

Youth and young adults < 25 years	HIV Infected	Sex Workers
Incarcerated	Substance Users	Pregnant Women

Barriers To Reaching Population

Prejudice and stigma towards race/HIV	Cultural and language barriers
Lack of knowledge of available services	Lack of knowledge of HIV
Economic disenfranchisement	Rural areas more isolated
Distrust of system	Lack of access to services

Priority Interventions

- Individual Level: Behavioral Skills Training, Safer Sex Negotiation Counseling in community and clinic settings.
- Group Level: Peer and Non-Peer Counseling and Risk Reduction Education, Skills Training and Social Support in community settings
- Community delivered counseling and testing

Goals

1. Decrease risk behavior and number of sexual partners.
2. Increase support among larger African American communities for HIV prevention and reduced stigma.
3. Increase integration of HIV in substance use, domestic violence and other broader health/support issues groups that reach women.
4. Increase number of African American women who have knowledge of their HIV status and are referred to on-going care and support services.

Target Population 3: White Men Who Have Sex With Men

Estimated Size: Minimum of 15,937 men, 15 – 44 years of age

Men who have sex with men (MSM) continue to remain a significantly affected population with HIV, regardless of age, race/ethnicity and residence. The largest proportion of persons estimated to be living with HIV in the state are men who have sex with men. The level of new HIV cases appears to be declining among white MSM. However, further assessments need to occur to determine if testing patterns have changed (particularly among young men under 25 years) or if there are other factors to confirm if "incident" cases are truly declining. Most white MSM live in the more urban counties and may have more sense of community than exists with African American MSM, reducing some of the prevention barriers. Most white MSM infected with HIV are older than 25 years of age. Increases in very high risk behaviors among young MSM living in other areas of the country, however, is cause for concern among young MSM in South Carolina.

Sub-Populations of Concern

Youth and young adults < 25 years	HIV Infected	Sex Workers
Substance Users	Older adults (44 years +)	
Internet "cruisers"		

Barriers To Reaching Population

Prejudice and stigma towards MSM	Rural areas more isolated
Complacency/security due to HART	HIV "fatigue"
Lack of access to services	

Priority Interventions

- Group Level: Multi-session Peer and Non-Peer Counseling and Risk Reduction Education, Skills Training and Social Support in acceptable settings
- Community Level: Social marketing interventions that utilize popular opinion leaders and role model stories.
- Other: Multiple individual counseling sessions focused on healthy sexual practices as well as focusing on other psychosocial needs (substance abuse, mental health issues);

Goals

1. Decrease risk behavior and number of sexual partners.
2. Increase integration of HIV in substance use, other broader health/support issues groups that are sensitive to MSM populations.
3. Increase number of white MSM who have knowledge of their HIV status and are referred to on-going care and support services.
4. Develop behavioral monitoring mechanisms for improved planning/interventions

Target Population 4: African American Male Injecting Drug Users

Estimated Size: 7,791 (All races/sexes)

There is an apparent decline in the number of HIV infections reported among both men and women due to injecting drug use (IDU). This decline needs further assessment to determine if it is reflective of true incidence/prevalence of HIV among IDU's. Among the estimated number of persons living with HIV who are IDU's, the majority of African American men (62%) compared to 16% are white men. The majority (97%) of recently diagnosed IDU cases are among persons 24 – 45 and above. The urban areas have more persons living with HIV due to injecting use. Due to legal barriers, South Carolina does not have needle exchange programs, which limits effective prevention efforts for this population.

Sub-Populations of Concern

Persons older than 25 years	HIV Infected	Sex Workers
Incarcerated	Other Substance Users	Homeless

Barriers To Reaching Population

Denial about drug use
Illegality of IDU
Rural areas more isolated
Prejudice and stigma towards race and drug use
Cultural and language barriers
Hard to reach due to locations of IDU activities
Distrust of system
Economic disenfranchisement

Priority Interventions

- Individual Level: Prevention Counseling, Skills Training
- Group Level: Peer and Non-Peer Counseling and Risk Reduction Education, Skills Training and Social Support
- Community Level: Peer and Non-peer Street and Community Outreach
- Community delivered counseling and testing

Goals

1. Decrease needle-sharing risks and behavior and number of sexual partners.
2. Increase support among larger African American communities for HIV prevention and reduced stigma.
3. Increase number of African American male IDU's who have knowledge of their HIV status and are referred to on-going care and support services.
4. Develop behavioral monitoring mechanisms for improved planning/interventions

Target Population 5: African American Female Injecting Drug Users

Estimated Size: 7,791 (All races/sexes)

There is an apparent decline in the number of HIV infections reported among both men and women due to injecting drug use (IDU). This decline needs further assessment to determine if it is reflective of true incidence/prevalence of HIV among IDU's. African American women account for 15% of recent cases due to injecting drug use; white women account for 7%. Due to legal barriers, South Carolina does not have needle exchange programs, which limits effective prevention efforts for this population. Other barriers include South Carolina's legal policy of reporting pregnant substance users (including IDUs) for prosecution which may deter women from seeking early and regular prenatal care.

Sub-Populations of Concern

Persons older than 25 years	HIV Infected	Sex Workers
Incarcerated	Substance Users	Pregnant women

Barriers To Reaching Population

Denial about drug use	Economic disenfranchisement
Illegality of IDU	Rural areas more isolated
Prejudice and stigma towards race and drug use	Cultural and language barriers
Hard to reach due to locations of IDU activities	Distrust of system

Priority Interventions

- Individual Level: Prevention Counseling, Skills Training
- Group Level: Peer and Non-Peer Counseling and Risk Reduction Education, Skills Training and Social Support
- Community Level: Peer and Non-peer Street and Community Outreach
- Community delivered counseling and testing

Goals

1. Decrease needle-sharing risks and behavior and number of sexual partners.
2. Increase support among larger African American communities for HIV prevention and reduced stigma.
3. Increase number of African American female IDU's who have knowledge of their HIV status and are referred to on-going care and support services.
4. Increase integration of HIV in substance use, domestic violence and other broader health/support issues groups that reach women.
5. Develop behavioral monitoring mechanisms for improved planning/interventions.

Target Population 6: White Male Injecting Drug Users

Estimated Size: 7,791 (All races/sexes)
There is an apparent decline in the number of HIV infections reported among both men and women due to injecting drug use (IDU). This decline needs further assessment to determine if it is reflective of true incidence/prevalence of HIV among IDU's. White men account for 16% of recently diagnosed IDU cases. Due to legal barriers, South Carolina does not have needle exchange programs, which limits effective prevention efforts for this population.

Sub-Populations of Concern

Persons older than 25 years	HIV Infected	Sex Workers
Incarcerated	Homeless	Substance Users

Barriers To Reaching Population

Denial of IDU activities
Prejudice and stigma towards IDU behavior
Rural areas more isolated
Cultural and language barriers
Not receptive and accessible to prevention messages/services
Economic disenfranchisement

Priority Interventions

- Group Level: Peer and Non-Peer Counseling and Risk Reduction Education, Skills Training and Social Support
- Community Level: Peer and Non-peer Street and Community Outreach
- Community delivered counseling and testing

Goals

1. Decrease needle-sharing risks and sexual behavior and number of sexual partners.
2. Increase integration of HIV in substance use, other broader health/support issues groups that serve high-risk male populations.
3. Increase number of white male IDU's who have knowledge of their HIV status and are referred to on-going care and support services.
4. Develop behavioral monitoring mechanisms for improved planning/interventions.

Note: African American Men Having Sex with Women is a new population added during the 2001 needs assessment process. The CPG will prioritize interventions for this population during 2002.

New Target Population: African American Men Having Sex with Women

Estimated Size: 272,229 men, ages 15 -44

African American men comprise approximately one-third of persons living with HIV due to heterosexual transmission (31%) and 37% of more recently diagnosed heterosexual cases. Many local HIV providers believe the proportion of African American men reporting heterosexual transmission is inflated due to stigma of male to male sex. However, it is recognized that many of these men have sex with women and as the number of African American women infected with HIV grows, the heterosexual risk to men will also grow. Additionally, many important programs developed by and for the African American community often focus more on women. African American men have fewer services provided specifically to meet their needs.

Sub-Populations of Concern

Men older than 25 years HIV Infected Incarcerated
Substance Users

Barriers To Reaching Population

Prejudice and stigma towards race/HIV
Lack of knowledge of available services
Economic disenfranchisement
Distrust of system
Cultural and language barriers
Lack of knowledge of HIV
Rural areas more isolated
Lack of access to services

Priority Interventions

- Group Level: Peer and Non-Peer Counseling and Risk Reduction Education, Skills Training and Social Support in community settings
- Culturally appropriate prevention marketing in settings targeting African American men, e.g. church programs, youth rallies, basketball events, barber shops, concerts, etc.
- Community delivered counseling and testing

Goals

1. Decrease risk behavior and number of sexual partners.
2. Increase support among larger African American communities for HIV prevention and reduced stigma.
3. Increase integration of HIV in substance use, other broader health/support issues groups that are directed to African American men.
4. Increase number of African American men who have knowledge of their HIV status and are referred to on-going care and support services.

Special Populations of Concern

The SC CPG acknowledges that there are special populations within each of the priority target populations and populations that are not currently considered "priority" as a result of the criteria used for prioritization. One reason for the latter is that data does not currently exist to adequately or accurately describe the extent of HIV among a population such as Hispanics. Within the prioritized populations, there are sub-populations of concern which have typically proven hard to reach or have specific needs and considerations, such as pregnant women, substance users or incarcerated persons. To further highlight and provide key issues of concern for prevention work, some of these special populations are described in more detail below.

Special Populations: The homeless

The homeless population in South Carolina is difficult to quantify. The special conditions of their situation make them especially hard to reach and prevent adequate case-management of HIV positive individuals within this group. Often, this population has mental health issues, substance abuse issues and unsafe sexual behavior that must be addressed. They are vulnerable to crime. The larger cities of Columbia and Charleston have homeless shelters and some limited HIV prevention services. Providers indicate that many homeless shelters have drug dealers in close proximity. Shelter policies requiring persons to be outside during the day create barriers for HIV infected persons to adhere to medication schedules.

Barriers

Inability to access system	Substance Use
Lack of knowledge of available services	Lack of knowledge of HIV
Economic disenfranchisement	Lack of access to services
Distrust of system	Frequent mobility creates challenges for follow-up

Intervention Recommendations

- Community based HIV testing services should be provided at homeless shelters
- Ongoing outreach education with focus on referral to services and risk reduction

Goals

1. Decrease risky behavior and number of sexual partners.
2. Increase support among other social services agencies for HIV prevention
3. Increase prevention services that link infected persons to care and supportive services and other prevention services such as substance use treatment, small group sessions, etc.

Special Populations: HIV Infected Persons

As of December 2000, there were 10,360 persons estimated to be living with HIV/AIDS in South Carolina (excluding out of state cases returning to SC). The growing number of persons living with HIV challenges both prevention and care service systems. Prevention needs are essential as sexual and substance use risk behaviors are occurring among persons living with HIV. Interviews with recently diagnosed persons with HIV indicate that substance use during past 5 years or present was reported by one-third of persons with HIV interviewed. Sexual risks reported by persons interviewed indicate that one-fourth (27%) of men paid some one for sex; 21% of women received either money or drugs for sex. Over half of men (53%) report not using a condom every time with their non-steady partner during the one year prior to their HIV diagnosis; 31% of women did not use a condom every time. Twenty-nine percent of men and 30% of women reported having at least one sexually transmitted disease (STD) during the past ten years.

Barriers

Fear of stigma/discrimination	Not feeling sick	Inability to access system
Denial of HIV status	Financial constraints	
Fear of disclosure & refection by sexual partners		

Intervention Recommendations

- Outreach efforts, especially in non-traditional settings, targeting persons who have not accessed counseling and testing services to provide HIV screening and if infected, referrals to on-going care services
- Peer-based interventions linking recently infected persons to care services and linking persons diagnosed infected during past few years but who have not successfully entered or maintained care services
- Enhanced/increased prevention case management services for HIV infected persons particularly in high prevalence areas of the state.

Goals

1. Decrease risky behavior and number of sexual partners.
2. Increase support among larger African American communities for HIV prevention and reduced stigma.
3. Increase prevention services that link infected persons to care and supportive services and other prevention services such as substance use treatment, small group sessions, etc.

Special Populations: Hispanics

One percent of total persons living with HIV infection are Hispanics, who comprise nearly 3% of the state's population (2000 estimates). Hispanics/Latinos represent the largest fastest growing segment of the population in South Carolina, with a 78% increase between 1990 and 1999. The Upstate and Coastal Regions of the state housed the largest segment of the permanent Hispanic/Latino population growth in South Carolina (88% Upstate and 76% Coastal). The median age for this group is 30 and declining due to increased births, and one in two females is of childbearing age. Median educational attainment for the respondent population is six years; 3% and 5% of the population is illiterate. Employment of the newly immigrated is concentrated in agriculture, processing, and construction. Nine out of ten of those newly immigrated to the state come from Mexico and are exclusively Spanish speaking "Language ' is a barrier to seeking and receiving health care services. Chief among the concerns were the lack of translators, prescriptions and doctor's orders that are written in English, and inconsistency of fluency levels of translators. Four out of five respondents reported that their chances of contracting HIV/AIDS were "no ne" or "do not know". Ninety-eight percent (98%) of the women who had been tested for HIV did so as part of prenatal or postpartum care.

Barriers

Language/lack of bilingual staff
Lack of transportation/obtaining driver's license
Inability to access system
Lack of knowledge of risks/transmission
Financial constraints

Intervention Recommendations

- Public information using Spanish television, radio, and newspapers and bilingual flyers/brochures placed in locations where Hispanics gather (businesses, schools, etc.).
- One-to-one outreach to provide risk reduction counseling and skills training
- Community delivered counseling and testing

Goals

1. Decrease risk behavior and number of sexual partners.
2. Increase support among larger Hispanic communities for HIV prevention and reduced stigma.
3. Increase integration of HIV in broader health/support issues groups that reach Hispanics
4. Increase number of Hispanics who have knowledge of their HIV status and are referred to on-going care and support services.

Special Populations: Substance Users, particularly crack-cocaine

Substance use (alcohol, crack-cocaine, and other illicit drugs) poses significant challenges for both prevention and care providers in South Carolina. Interviews during 1998-1999 with recently diagnosed persons with HIV indicate that substance use during past 5 years or present was reported by one-third of persons with HIV interviewed: 33% reported being potential alcoholic, 38% used illicit drugs during past five years. Nine percent reported ever injecting drugs and 18% had used crack. More men than women reported each substance use related risk. Recent syphilis elimination outbreak response activities in three areas of the state indicate a significant number of syphilis cases and partners are involved with substances primarily crack-cocaine.

Barriers To Reaching Population

Denial about drug use
Illegality of drug use
Prejudice and stigma towards race and drug use
Hard to reach due to locations of drug use activities
Economic disenfranchisement
Rural areas more isolated
Cultural and language barriers
Distrust of system

Intervention Recommendations

- Individual Level: Prevention Counseling, Skills Training
- Community Level: Peer and Non-peer Street and Community Outreach
- Community delivered counseling and testing using mobile van services offering HIV, other STD and health screenings

Goals

1. Decrease drug use behavior and number of sexual partners.
2. Increase number of substance users who have knowledge of their HIV status and are referred to on-going care and support services.
3. Increase integration of HIV in substance use, domestic violence and other broader health/support issues groups that reach women.

Special Populations: Native Americans

According 2000 Census data, there are over 13,700 Native Americans living in South Carolina, representing about 12 tribes, clans or bands. The Catawba Indian Nation is the only Federally recognized tribe in the state. Of persons living with HIV in the state as of December 2000, 0.1% were Native American. Based on national estimates, Native Americans tend to have lower median incomes, higher poverty rates, higher STD rates and substance use rates than the U.S. population as a whole. There is a need for more culturally relevant education materials and programs for Native Americans in the state.

Barriers

Lack of culturally competent staff
Lack of transportation
Inability to access system
Lack of knowledge of risks/transmission
Financial constraints

Intervention Recommendations

- Public information using Native American television, radio, and newspapers and bilingual flyers/brochures placed in locations where Native Americans gather (businesses, schools, etc.).
- One-to-one outreach to provide risk reduction counseling and skills training
- Community delivered counseling and testing

Goals

1. Reduce sexual risk behaviors and substance use.
2. Increase involvement of Native Americans and Native American community leaders in planning and implementation of education programs.
3. Increase culturally sensitivity training for health care providers who work with Native Americans.
4. Increase substance use referral and treatment services.

Special Populations: Pregnant Women

There are over 3,000 women estimated to be living with HIV in South Carolina, a 275% increase from 1990 to 2000. More than eight of every ten women diagnosed (84%) with HIV/AIDS in SC are African American. An estimated 100 HIV infected women deliver live births each year.

Preventing perinatal HIV transmission is one of the success stories in our fight against the HIV epidemic. Evaluation of prevention of perinatal HIV transmission efforts in South Carolina indicate that an estimated 95-99% of HIV infected women are aware of their HIV status prior to delivery of their infant and that nearly 80% are prescribed the full course of antiretroviral treatment according to U.S. Public Health Service treatment guidelines. These and provider survey data indicate that, overall, pregnant women in South Carolina are being routinely offered HIV testing and for those infected, being offered treatment. These practices have resulted in a decline of the number of HIV infected infants due to perinatal transmission from 15 in the 1994 birth cohort to 2 infants diagnosed in the 1999 birth cohort and 5 in 2000 (preliminary data).

Eighty percent of adolescent and adult Ryan White Title IV pediatric clients live at or below the federal poverty level, while 91% of all Title IV clients are either covered by Medicaid or are uninsured. Substance use is a significant factor creating challenges for prevention and care. Nearly one-third (30%) of women with HIV interviewed during 1998 – August 2000 indicated using illicit drugs during the past 5 years; 19% indicated being potentially alcoholic, and 16% used crack.

Barriers

Lack of prenatal care/inadequate prenatal care
Lack of medication adherence for those infected
Lack of transportation in rural areas
Substance use
Denial/fears of stigma
Complex psychosocial issues
Economic constraints
System barriers: need for on-going provider training on public health recommendations for screening/treatment protocols

Intervention Recommendations

- Community–level and outreach HE/RR activities targeting African American women, integrating messages regarding importance of prenatal care and the benefit of perinatal HIV prevention treatments if infected.
- Prevention case management for HIV infected pregnant women or those at high risk

Goals

1. Confine number of perinatally acquired HIV infection to no more than 5 per year
2. Increase number of HIV infected pregnant women receiving prevention case management services in high prevalence counties
3. Increase proportion of HIV infected women who receive/adhere to PHS treatment guidelines

Special Populations: Youth and Young Adults, 13 – 24 years

Youth and young adults 15-24 years accounted for 13% of the new HIV/AIDS diagnosed in 2000. There is a high level of unprotected sexual activity among teenagers in South Carolina: 58% percent of teens report being currently sexually active, and 61% of those reported using a condom during last intercourse. Young sexually active women 15 – 19 years have the greatest prevalence of chlamydia. Education and risk reduction efforts targeting youth can be challenging due to several barriers. Parents may be uncomfortable addressing the issues of youth sexuality; teachers are constrained on what topics can be addressed in school health education curricula; internet and other media provide explicit sexual messages and opportunities.

Barriers

Perceived immortality
Lack of awareness of HIV issues
Limited access to youth appropriate/ friendly sites
Political/social regulations on school education
Peer pressure/maturity level

Intervention Recommendations

- Peer led education and counseling programs targeting out of school youth
- Age and culturally appropriate prevention marketing programs
- Community events, focusing on range of health and life skills issues with integrated HIV and STD education

Goals

1. Decrease risk behavior and number of sexual partners.
2. Increase support among larger African American communities for HIV prevention and reduced stigma.
3. Increase integration of HIV in health promotion and life-skills curricula that reach youth.
4. Increase number of youth who have knowledge of their HIV and STD status and are referred to care and support services.

2000 Priority Setting Process: How were the priority populations and interventions determined?

In HIV prevention community planning, the term target population refers to populations that are the focus of HIV prevention efforts due to high rates of HIV infection. Target populations are often defined based on a combination of characteristics such as race or ethnicity, age, gender, risk factor/behavior, and geographic location. An intervention is defined as a specific activity (or set of related activities) intended to bring about HIV risk reduction in a particular target population using a common method of delivering the prevention message. An intervention has distinct process and outcome objectives and a protocol outlining the steps for implementation

The SC CPG empowered the Priority Setting Workgroup (PSW) with completing the task of conducting the priority setting process that had been agreed upon by the entire CPG in1999. The priority setting process was conducted following an 8 step model presented by the Academy for Educational Development (AED). The 8 step model consisted of the following steps:

1. Identify factors for prioritizing populations.
2. Create a list of populations.
3. Gather data on each factor for each population.
4. Prioritize populations.
5. Identify factors for prioritizing interventions.
6. Create a list of interventions.
7. Gather data on each factor for each intervention.
8. Prioritize interventions.

The PSW identified a list of factors for prioritizing both populations and interventions and obtained input from DHEC health department staff, HIV prevention collaboration members (contractors), and others about the list of factors or criteria. Based on the input, the PSW developed a list of five factors for prioritizing target populations and ten factors for prioritizing interventions.

The five population factors and their relative weight based on importance are listed below:

FACTORS	WEIGHTS (Importance)
Disproportionate Impact (expressed as a rate)	3
Estimated Prevalence Based on Reported HIV/AIDS Cases	3
Estimated Incidence Based on Reported HIV/AIDS Cases	3
Surrogate Markers for Risk Behaviors	2
Prevalence of Risk Behavior	2

A list of populations based input from community respondents and local HIV prevention providers was developed. This list of over 375 populations were compiled and categorized based on the most frequent response and included the following:

Youth
A. Sexually Active
B. Substance Use
C. Gay, Lesbian, Bisexual and Questioning Youth

Men
A. Men who have Sex with Men (MSM)
1. African American
B. Heterosexual
1. African American
C. Substance Use

Women
A. Heterosexual
1. African American
B. Substance Use

The above list of populations was submitted to the DHEC/CPG Epidemiology Workgroup to collect relevant data to use in the priority setting. This workgroup further narrowed down the population list to the following populations: African American Men Who have Sex with Men (AA MSM), ages 15-44; White MSM 15-44; African American Women Who have Sex with Men (AA WSM), ages 15-44; African American Male IDUs, ages 20-44; African American Female IDUs 20-44, and White Male IDUs 20-44.

The PSW then developed a priority setting worksheet used by the CPG for ranking the six target populations using the five factors.

Interventions:
A similar process of developing a list of factors, with input from the CPG and HIV prevention providers, and then gathering information on the factors for each type of intervention by each target population was conducted. The intervention factors included: (1) Priority Needs, (2) Outcome Effectiveness, (3) Population and Behavior, (4) Developed with Target Population Input, (5) Community Norms and Values, (6) Feasibility of Intervention, including the availability of resources, (7) Cost Effectiveness, (8) Theory, (9) Legality of Interventions, and (10) Ability to Evaluate. Intervention Factors were not weighted.

The Priority Setting Workgroup (PSW) used these factors as a guide in performing a literature review to determine priority interventions. As the PSW conducted the literature review, challenges that they faced were not finding information that specifically targeted the populations selected, and not finding descriptions of interventions that included all of the factors. As a result, the PSW adjusted its process and reviewed articles/research descriptions if the target population

represented 50% or more of the subjects in the study and the interventions identified had a behavior change lasting longer that six months. These articles were included in a matrix that the PSW reviewed utilizing the 10 factors listed above for prioritizing interventions.

Based on input from DHEC staff that attended CDC's Evaluation Guidance Training for Health Departments in February 2000, the list of CDC intervention types was adopted by the PSW as the list of interventions for priority setting. The PSW prepared a list of priority interventions for each target population with a summary description of the research and findings. The CPG voted in July 2000 to accept the recommendations of the PSW for priority interventions.

The CPG only prioritized Health Education/Risk Reduction interventions. Reasoning that the other intervention types such as counseling and testing, partner counseling and referral services, health communications/public information, capacity building, STD linkages are all essential elements of a comprehensive program, the CPG and PSW did not think it was necessary initially to include those in a priority setting process. However, as a result of the 2001 Phase I needs assessment process, updated literature information and CDC's Strategic Plan, the CPG recommended that community based counseling and testing services should be included as a recommended intervention for each population. This is reflected in the population descriptions in this Chapter, along with other listed recommendations.

Barriers and Challenges to Priority Setting

The PSW found it challenging to find a sufficient number of research articles that included detailed descriptions of the factors by the specific type of populations that had been selected. In the future the CPG may need to conduct a broad review of the literature by less specific populations (like MSM, instead of AAMSM) in order to obtain the information it needs to determine priority interventions. In addition, at the time of priority setting, there was not an inventory of interventions being provided by target population by the different contractors and local health department staff across the state. With an inventory of interventions and specific resources, the CPG could do a better job of conducting a gap analysis and prioritizing.

Additionally, the CPG acknowledges that surveillance data indicate an apparent decline in the number of new HIV infections diagnosed among injecting drug users (all racial populations). For the next priority setting process, the DHEC will attempt to validate this apparent trend with seroprevalence surveys among injecting drug users in both community and treatment settings. If the prevalence estimates confirm a declining trend/lower proportion of total HIV cases attributed to IDU risk, the CPG will also re-examine the definition of "disproportionate impact" as a factor for priority setting.

Summary of Key Challenges and Recommendations for Future Priority Setting	
Challenge	Recommendation
1. Interventions are not ranked 2. Updated needs assessment information was not available at time of 2000 priority setting, including an inventory of interventions being provided by target population by the different contractors and local health department staff across the state. 3. Literature by specific priority population was limited for some populations; some interventions not applicable to South Carolina "community norms" 4. Recent needs assessment/gap analysis revealed need for revisiting priority interventions for some populations, e.g. IDU's, African American MSM.	1. Complete ranking after completion of Phase II and III population-focused needs assessment 2. Update resource inventory and utilize new web-based reporting system for funded prevention providers. 3. Broaden literature review; provide on-going training and discussions with CPG members on intervention types, the science/theory basis for the intervention, and effectiveness. 4. For next priority setting process, greater attention needs to given to community norms, values as a factor for selecting priority interventions